ARKANSAS INSURANCE DEPARTMENT
1200 WEST THIRD STREET
LITTLE ROCK, ARKANSAS 72201
PHONE 501-371-2750
FAX 501-683-2604

SELF-FUNDED SINGLE EMPLOYER PLANS, COLLECTIVELY BARGAINED PLANS, MUTIPLE EMPLOYER TRUST, AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (ARK. CODE ANN. 23-92-101)

1. NAME OF PLAN:_____

2. TAX ID NUMBER OF PLAN: _____

3. ADDRESS OF PLAN: _____
   Street, number or P.O. Box City and State Zip

4. NAME AND TITLE OF CONTACT _____

5. TELEPHONE NUMBER OF CONTACT _____

6. TYPE OF PLAN, ARRANGEMENT, ASSOCIATION, OR TRUST: (CHECK ONE)

_____Single Employer, Self Funded Plan

_____ Fully Insured Multiple Employer Welfare Arrangement

_____ Collectively Bargained Welfare Benefit Plan (Taft-Hartley Trust)

_____ Not Fully Insured Multiple Employer Welfare Arrangement

_____ Multiple Employer Trust

6. List all States in which the Plan is registered or licensed (attach copies of license/registration to this form)

   _____

7. List all States in which the Plan is doing business or covers individuals:
   _____

   _____

8. Has the Plan had any complaints regarding claim payment in other states: _____yes _____no
   (If yes attach a copy of the documentation of the complaint and documentation of the resolution of the complaint)

9. NAME OF THIRD PARTY ADMINISTRATOR:_____

10. FEDERAL TAX ID OF THE THIRD PARTY ADMINISTRATOR _____

11. CONTACT PERSON OF TPA _____

12. CONTACT'S PH0NE NUMBER _____

13. NUMBER OF INDIVIDUAL ARKANSAS CITIZENS COVERED BY THE PLAN OR ARRANGEMENT: _____

14. IF A MULTIPLE EMPLOYER WELFARE ARRANGEMENT (OR TRUST) WHICH IS FULLY INSURED, STATE NAME, ADDRESS AND TELEPHONE NUMBER AND NAIC ID NUMBER OF DISABILITY OR HEALTH INSURER UNDERWRITING THE PLAN *(a copy of the declaration page/certificate and policy must be attached to this application)*

    Name of Company _____ NAIC #_____

    Name of Company Contact _____ Phone Number _____

15. IF A MULTIPLE EMPLOYER WELFARE ARRANGEMENT OR TRUST WHICH IS NOT FULLY INSURED, STATE NAME, ADDRESS AND TELEPHONE NUMBER OF PERSON (S) ADMINISTERING THE PLAN, WHETHER OR NOT A THIRD PARTY ADMINISTRATOR:
    Name of Administrator _____

    Address of Administrator _____

    Phone Number of Administrator _____

AFFIDAVIT

I, THE UNDERSIGNED, DO HEREBY SWEAR OR AFFIRM UNDER OATH THAT THE INFORMATION SUMITTED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____

NAME AND TITLE DATE

State of _____

County of _____

Subscribed to and sworn or affirmed before me on this _____ Day of _____, 200_____

My Commission Expires: _____

_____

Notary Public seal

SELF-1-LIC(4-02)